it receives the information from the hospital, or the HMO or CMP, or both.

(c) *Financial responsibility.* (1) *General rule.* Except as provided in paragraph (c)(2) of this section, the HMO or CMP continues to be financially responsible for the costs of the hospital stay until noon of the calendar day following the day the PRO notifies the enrollee of its review determination.

(2) *Exception.* The hospital may not charge the HMO or CMP (or the enrollee) if—

(i) It was the hospital (acting on behalf of the enrollee) that filed the request for immediate PRO review; and

(ii) The PRO upholds the noncoverage determination made by the HMO or CMP.

[59 FR 59941, Nov. 21, 1994]

§ 417.606 Organization determinations.

(a) *Actions that are organization determinations.* An organization determination is any determination made by an HMO or CMP with respect to any of the following:

(1) Payment for emergency or urgently needed services.

(2) Any other health services furnished by a provider or supplier other than the HMO or CMP that the enrollee believes—

(i) Are covered under Medicare; and

(ii) Should have been furnished, arranged for, or reimbursed by the HMO or CMP.

(3) The HMO's or CMP's refusal to provide services that the enrollee believes should be furnished or arranged for by the HMO or CMP and the enrollee has not received the services outside the HMO or CMP.

(4) Discontinuation of a service (such as a skilled nursing facility discharge), if the enrollee disagrees with the determination that the service is no longer medically necessary.

(b) *Actions that are not organization determinations.* The following are not organization determinations for purposes of this subpart:

(1) A determination regarding services that were furnished by the HMO or CMP, either directly or under arrangement, for which the enrollee has no further obligation for payment.

(2) A determination regarding services included in an optional supplemental plan (see § 417.440(b)(2)).

(c) *Relation to grievances.* A determination that is not an organization determination is subject only to a grievance procedure under § 417.436(a)(2).

[59 FR 59942, Nov. 21, 1994, as amended at 62 FR 23374, Apr. 30, 1997]

§ 417.608 Notice of adverse organization determination.

(a) If an HMO or CMP makes an organization determination that is partially or fully adverse to the enrollee, it must notify the enrollee of the determination—

(1) Within 60 days of receiving the enrollee's request for payment for services; or

(2) As specified in § 417.609(c)(3) for expedited organization determinations.

(b) The notice must—

(1) State the specific reasons for the determination; and

(2) Inform the enrollee of his or her right to a reconsideration, including the right to and conditions for obtaining an expedited reconsidered determination.

(c) The failure to provide the enrollee with timely notification of an adverse organization determination as specified in paragraph (a) of this section or in § 417.609(b) (concerning time frames for expediting certain organization determinations) constitutes an adverse organization determination and may be appealed.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59942, Nov. 21, 1994; 62 FR 23375, Apr. 30, 1997]

§ 417.609 Expediting certain organization determinations.

(a) An enrollee, or an authorized representative of the enrollee, may request that an organization determination as defined in §§ 417.606(a)(3) and (a)(4) be expedited. The request may be made orally to the HMO or CMP.

(b) The HMO or CMP must maintain procedures for expediting organization determinations when, upon request from an enrollee or authorized representative of the enrollee, the organization decides that making the determination according to the procedures

and time frames set forth in §417.608(a)(1) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(c) The procedures must include the following:

(1) Receipt of oral requests, followed by written documentation of the oral requests.

(2) Prompt decision-making regarding whether the request will be expedited, or handled within the standard time frame set forth at §417.608(a)(1), including notification of the enrollee if the request is not expedited.

(3) Notification of the enrollee, and the physician as appropriate, as expeditiously as the enrollee's health condition requires, but within 72 hours of the request. An extension of up to 10 working days is permitted if requested by the enrollee or if the HMO or CMP finds that additional information is necessary and the delay is in the interest of the enrollee.

(i) Notification must comply with §417.608(b), concerning the content of a notice of adverse organization determination.

(ii) If the initial notification is not in writing, written confirmation must be mailed to the enrollee within 2 working days.

(iii) In cases for which the HMO or CMP must receive medical information from a physician or provider not affiliated with the HMO or CMP, the time standard begins with receipt of the information.

(4) Granting the request of a physician, regardless of whether the physician is affiliated with the organization or not, to expedite the enrollee's request.

[62 FR 23375, Apr. 30, 1997]

§ 417.610 Parties to the organization determination.

The parties to the organization determination are—

(a) The enrollee;

(b) An assignee of the enrollee (that is, a physician or other supplier who has provided a service to the enrollee and formally agrees to waive any right to payment from the enrolee for that service);

(c) The legal representative of a deceased enrollee's estate; or

(d) Any other entity determined to have an appealable interest in the proceeding.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59942, Nov. 21, 1994]

§ 417.612 Effect of organization determination.

The organization determination is binding on all parties unless it is reconsidered in accordance with §§417.614 through 417.626, or revised in accordance with §417.638.

[50 FR 1346, Jan. 10, 1985, as amended at 59 FR 59941, Nov. 21, 1994; 62 FR 25855, May 12, 1997]

§ 417.614 Right to reconsideration.

Any party who is dissatisfied with an organization determination or with one that has been reopened and revised may request reconsideration of the determination in accordance with the procedures of §417.616, concerning a request for reconsideration, or §417.617, concerning certain expedited reconsiderations.

[62 FR 23375, Apr. 30, 1997]

§ 417.616 Request for reconsideration.

(a) *Method and place for filing a request.* A request for reconsideration must be made in writing and filed with—(1) The HMO or CMP that made the organization determination;

(2) An SSA office; or

(3) In the case of a qualified railroad retirement beneficiary, an RRB office.

(4) In the case of a request for an expedited reconsideration, as provided for in §417.617 (concerning certain expedited reconsiderations), the HMO or CMP.

(b) *Time for filing a request.* Except as provided in paragraph (c) of this section, the request for reconsideration must be filed within 60 days from the date of the notice of the organization determination.

(c) *Extension of time to file a request.* (1) *Rule.* If good cause is shown, the HMO or CMP that made the organization determination may extend the time for filing the request for reconsideration.